VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 8, 2016

Ms. Kim Russell-Peck, Manager
Kirby House, Inc.
64 South Main Street
Waterbury, VT 05676-1517

Dear Ms. Russell-Peck:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on June 1, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0058	A. BUILDING: _____ B. WING _____	06/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIRBY HOUSE, INC.	64 SOUTH MAIN STREET WATERBURY, VT 05676

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R100	Initial Comments: An unannounced, onsite re-licensure survey was conducted by the Division of Licensing and Protection between 5/31/2016 and 6/1/2016. The following deficiencies were identified:	R100		
R165 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10,d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the house Registered Nurse failed to ensure that a process was established to monitor for medication side effects for 1 of 6 residents who were being administered antipsychotic medications (Resident #1). The findings include:	R165	R165 An AMS test was performed on Resident #1 to achieve a baseline for which side effects of the antipsychotic medications will be monitored. Our nursing staff will continue to monitor for these side effects by using these assessment tools. Our admission checklist and nursing assessment tool have been updated to include an area that specified whom will be monitoring the patient if indeed they are using any of the antipsychotic medications. This will either be performed by the prescribing physician or our nursing team. See addendum on last page.	6.20.16

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy Russell-Kelly TITLE: Manager (X6) DATE: 6/21/16

R165-R302 POC accepted 7/7/16 with addendum (see last page). GColemanRN/pmw

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R165	Continued From page 1 Per record review, Resident #1 had physician orders to take Risperidone (an antipsychotic medication) 1 mg twice daily. Per record review, there was no evidence that the facility had monitored for medication side effects since the resident was admitted to the facility in early April 2016. On 5/31/16 at approximately 3:20 PM, the house Registered Nurse (RN) confirmed that for Resident #1, there had been no monitoring for Risperidone side effects and that a process would need to be established to ensure that monitoring occurred.	R165		
R179 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Helmlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens.	R179	R179 Mandatory staff in-service have been scheduled from now through the end of the year. All required areas of education will be covered during these scheduled in-services. In addition our in-service attendance log will now include the actual time that the in-service was conducted. I.e., 1:00pm-3:00pm	6.30.16

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R179	Continued From page 2 maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on review of staff training files and staff interview, the residential care home failed to ensure that 5 of 5 staff members providing direct care to residents completed 12 hours of required training in the calendar year. The findings include: Per review of staff training records, 5 of 5 direct care staff members lacked evidence of completing at least 12 hours of annual training for the calendar year 2015. The staff had 2 in-service trainings (4/9/15 and 12/3/15) which the facility's house manager reported usually run 1 1/2 - 2 hours and covered mandatory topics. On 5/31/16 at 1:30 PM, the facility house manager confirmed that direct care staff did not complete 12 hours of training for 2015.	R179		
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision	R181	R181 All record checks for PCA#5 have been submitted. All other employee files have been reviewed for missing documentation. Record checks for all employees are performed prior to hire and annually.	6-30-16

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R181	Continued From page 3 shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview, the Residential Care Home failed to ensure that the required background checks had been completed for 1 of 5 staff members reviewed. Findings include: Per record review, PCA #5 (personal care attendant) who provides direct care to residents, did not have any of the required background checks completed prior to the start of his/her employment on 11/1/12 thru the date of the survey on 6/1/16. On 6/1/16 at 9:15 AM, the home's administrator confirmed that mandatory background checks had not been completed for PCA #5.	R181		
R222 SS=D	VI. RESIDENTS' RIGHTS 6.7 The resident's right to privacy extends to all records and personal information. Personal information about a resident shall not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts	R222		

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R222	Continued From page 4 from or information contained in such records shall be subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store closed medical records in a manner that ensures that they are protected from unauthorized access and that resident's rights for privacy are maintained. The findings include: During a tour of the facility on 5/31/16 beginning at 9:30 AM, multiple stacked cardboard file boxes containing the medical records of residents who no longer reside in the facility were observed to be stored in a room on the second floor that was unlocked and accessible to residents who live in the home as well as staff members. When the house manager attempted to close and lock the door, s/he was not able to do so and reported that the building had shifted and the door would need to be shaved to get it to close. At the time of the observation, the manager confirmed that the medical records were not stored in a manner to prevent unauthorized access.	R222	R222 A contactor was called immediately to come and fix the door. Review of resident rights and policy will be done at the next in-service. Inspection of the door will be added to our revolving maintenance schedule to ensure it stays in compliance.	6.20.16
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or	R247		

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R247	Continued From page 5 heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to consistently label and date perishable foods. The findings include the following: Per tour of the Care Home's kitchen on 5/31/16 beginning at approximately 9:30 AM, in refrigerator #3 there were multiple containers of bulk salad dressings that were not dated as to when opened; smaller containers that were reportedly filled from the bulk salad dressing containers and put out for resident use, were not labeled for contents or dated when filled. In the facility freezers #1, #2 and #3, there were opened bags of mixed vegetables, meat patties, bacon, french fries and tater tots that were not dated as to when opened. The 2 bulk packages of bacon slices had been repackaged in clear plastic wrap and not dated. The above findings were confirmed by the house manager at the time of the tour; s/he confirmed that the foods should have been dated and labeled.	R247	R247 Immediately all open containers including but not limited to salad dressings, mixed vegetables, meat patties, bacon, French fries and tater tots were discarded. Anything currently opened and stored in the refrigerator or freezers is dated. Policy for food safety and sanitation will be reviewed with all staff.	7.5.16
R251 SS=E	VII. NUTRITION AND FODD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination.	R251	R251 1. Fan was immediately removed and cleaned. 2. Refrigerators and freezers were all thoroughly cleaned inside and out.	

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R251	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store and protect all food and drink from dust and other sources of contamination. The findings include: Per observation/inspection of the kitchen including the refrigerators and freezers in the presence of the facility house manager on the morning of 5/31/16, the following were identified: 1. A heavily dust soiled fan was in use and blowing in the direction of the food preparation table and across the kitchen where utensils and cooking implements were stored. 2. Refrigerator #2 was observed to have dark crumbs and dark particles on the lower shelf. Freezer #1 had dried crumbs/debris on the bottom; packaged food was stored on top of the debris. Freezer #3 had loose, unpackaged tater tots on the bottom of the freezer along with dried crumbs and debris. Packaged foods were in contact with the debris. Freezer #4 had loose, unpackaged fish sticks on the bottom of the freezer along with crumbs and debris; packaged foods were in contact with the crumbs and debris. Per interview with the house manager, s/he confirmed the above findings at the time of the observation on the morning of 5/31/16. On 6/1/16 when asked for the facility kitchen cleaning schedule, the house manager confirmed that the refrigerators/freezers were due for cleaning.	R251	R251 Cont These items are both on the cleaning schedule but will now be moved to accommodate them being done more frequently.	6.20.16
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment	R266		

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R288	Continued From page 7	R266	R266	

9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the home failed to provide and maintain a safe, functional, sanitary, homelike and comfortable environment. Findings include:

During a tour of the facility with the home's manager on 5/31/16 beginning at approximately 9:30 AM and on 6/1/16 at 9:25 AM, the following observations were made:

1. Electrical wires were exposed on the far end wall in the "big" living room where a wall sconce had been removed.
2. Four nail heads were lifted up on the short ramp leading from the hallway to the main dining room creating a trip hazard as well as risk for injury if stepped on without shoes.
3. There were no grab bars/handrails installed by the toilet in the second floor main bathroom or in the private bathrooms in room 203, 206 and 304.
4. On the second floor, the cleaning supply closet was left unlocked and out of site/unsupervised by staff; the closet contained bulk size quantities of poisonous cleaning chemicals, including Lysol, bleach, rug cleaners and others.
5. Baseboard radiator end caps were missing exposing sharp fins and metal edges in the "small" living room and dining room. In room 206 the end cap was missing and the front plate of the baseboard was loose and falling off the baseboard.
6. In room 209 the floor tiles at the entrance to the room (by the doorway) were loose and moved

1. Wall sconces will be put back up as they were removed for painted.
2. Nails will be removed and replaced.
3. Grab bars will be installed in the 2nd floor main bath and in private baths for rooms 203, 206 and 304.
4. Policy on poisonous cleaning chemicals will be reviewed with all staff. This includes making sure they are kept in a locked cabinet or storage area.
5. Heating contractor has been called and came by to take measurements on the units that need replacement parts. They are trying to locate the parts at this time and will come and install them as soon as they are obtained.
6. New flooring tiles have been ordered and will be installed as soon as they arrive. Our contractor also came to look at the areas that need linoleum replacement. He is suggesting some repairs to the sub floor and as soon as that is completed they will lay new linoleum.
7. An inspection of all window wells will be performed. Areas of chipping/peeling paint will be scraped down and repainted this including rooms 210 and 211. Area

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R266	Continued From page 8 when stepped on. In room 203 and 204, the linoleum was cracked and lifted by the toilets. The linoleum in front of the washer and drier was missing and exposed subfloor that was soiled and difficult to clean; the edge of the linoleum by the machines was lifted up creating a trip hazard. (Residents have the choice of using the laundry room to wash their own clothes). 7. In the "small" front living room, there was an area approximately 4 ft. long x 18 inches high where the paint on the wall was heavily peeling and chips were observed on the floor. In rooms 210 and 211, the paint on the window frames was heavily cracked and chipping and the window wells contained large amounts of paint dust and chips. Not all windows were observed during the survey as some rooms were occupied at the time of the tour. In the "big" living room, the paint on a shelf over the radiator was peeling and lifting up from the surface. 8. In the dining room, a box fan that was in use, was heavily soiled with dust and blowing in the direction of the tables where meals are served. 9. Room 302 was observed to have no handle on the door on the hallway side. (The room was not entered as was occupied at the time.) 10. Carpets were heavily soiled with dark drip marks and dark soiling in rooms 101, 206 and 208. In room 202 the house manager reported the carpet was stained with urine in multiple areas. In the hallway outside of room 202, dried (wetness) stains were observed. 11. On the main stairway (to the second floor), a rubber stair runner was broken with an approximate 6 inch piece missing that would cover the nose of the stair tread creating a risk for misstep and fall from the stairs. 12. A vinyl covered chair in "big" living room, was missing the vinyl covering on the distal part of both of the arms exposing open cell foam that	R266	in "small" Livingroom will be scraped and have a more heat resistant paint applied. 8. Fans were immediately removed and cleaned. They are on our cleaning schedule to be done monthly. They had just recently been removed from storage and staff had neglected to clean them first. This has been reviewed with all staff and they continue to be on our monthly cleaning list. 9. Door handle will be installed. Room currently is unoccupied. This had come up to be addressed on our maintenance check. 10. All carpets scheduled to be cleaned with attention given to rooms 101, 202, 206 and 208. This is already on our semiannual maintenance schedule. 11. New rubber stair treads have been ordered and will be installed when they arrive. Monitoring the condition of all stair treads will be put on the maintenance schedule. 12. Chair has been removed. 8.15.16	

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R266	Continued From page 9 cannot be cleaned adequately. The above observations were confirmed with the home manager at the time of the 2 tours.	R266		
R291 SS=D	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure that the temperature of hot water in resident areas did not exceed 120 degrees Fahrenheit (F). Findings include: Per review of facility temperature logs from 1/4/16-5/3/16, the water temperature in the first floor bathroom sink (used by residents) exceeded 120 degrees (F) on 5/3/16 (tested 122 degrees (F)). Following the high temperature reading, the water temperature in resident areas was not retested until the day of the survey on 6/1/16 when the first floor bathroom sink water was tested by the surveyor at 130 degrees (F). The House Manager (HM) was notified and water temperatures were retested by the HM, with the first, second and third floor bathroom sink water temperatures each testing 122 degrees (F). On 6/1/16 at approximately 10:30 AM, the HM confirmed that water temperatures in resident areas exceeded 120 degrees (F) and reported s/he will contact the facility plumber to adjust the temperature and would obtain a new	R291	R291 Facility plumber was contacted immediately. They came out to the facility on June 2nd and were unable to recreate a water temperature of 130 degrees at any single faucet. They did adjust water temps going to all resident areas of the house. We obtained a new thermometer and we will monitor these temps weekly for the next four weeks. At that time if temps are stable we will go back to monthly monitoring.	6.3.16

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R291	Continued From page 10 thermometer based on the discrepancy between the readings between the surveyor and house thermometers.	R291		
R302 SS=E	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on observation, staff record reviews and staff interviews, the community care home failed to assure that fire drills were conducted on at least a quarterly basis and were rotated during the times of day among morning, afternoon, evening, and night. The details are as follows: Per review of the residence fire drill logs for 2015 and to date in 2016 there are no overnight fire drills in any quarter. Further, the community care home had no evidence that reflects any fire drills were done on any shift between November 2015 and March 2016. This is confirmed by the home's manager during interview on 06/01/2016.	R302	R302 Fire drill policy and procedure will be reviewed by both staff and management. Fire drills have been performed during each of the four times a day on a bi-monthly basis. Documentation was not done to properly show this. We have reviewed out documentation of these events and staff is now trained to fill out the log themselves versus management doing it.	6.20.16

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R302	Continued From page 11 The manager also stated that s/he did not know that fire drills times needed to be rotated among 4 different times in a 24 hour period.	R302		

Kirby House, Inc.
64 South Main
Waterbury, Vermont
(802) 244-8998

June 29, 2016

Addendum to P.O.C. resulting from survey dated 5/31/16-6/1/16 for Kirby House Inc. (Provider #0058)

R 179: Management will ensure that the in-service is completed and documented.

R181: Management will ensure that these record checks are complete and documents are in the appropriate records.

R222: Management will review all monthly, quarterly and yearly maintenance schedule to ensure their completion.

R247: FSD will inspect all refrigerators and freezers weekly for compliance.

R251: Cleaning schedule and inspection will be monitored by management.

R266: Building inspections performed by housekeeping staff and management.

R291: Management will monitor hot water temps and take appropriate actions if necessary to ensure compliance.

Kim Russell-Peck
Administrator